TAPESTRY
CHRISTIAN EARLY LEARNING

9280 No.2 Road, Richmond, BC V7E 2C8
(604)277-1079
Info@tapestryearlylearning.com

April 1, 2021

Dear Parents/Guardians,

Thank you for choosing Tapestry Christian Early Learning! Enclosed, you will find the Registration Package for the 2021 Summer Program.

Registration is on a first come, first serve basis, with all required information complete.

When registering please ensure you have included the following:

☐ All forms completed and signed

☐ Program fee (cheque payable to Tapestry Christian Early Learning)

☐ Copy of current immunization record (if child does not currently attend TCEL)

☐ Copy of birth certificate (if child does not currently attend TCEL)

☐ 2 Current photos of child (if child does not currently attend TCEL)

If you have any questions, or need assistance in completing the registration package, please feel free to speak with Gyssel Romano, Program Director.

Sincerely,

Gyssel Romano

Program Director

Tapestry Christian Early Learning

Student start date: _____

TAPESTRY CHRISTIAN EARLY LEARNING
2021 SUMMER PROGRAM REGISTRATION FORM

Personal Information

Child's Name: _____ DOB: _____
First Middle Surname dd/mm/yyyy

Name child responds to: _____ Gender: M _____ F _____

Address: _____

City: _____ Postal Code: _____ Phone: _____

Child's First Language: _____ Child's Second Language:(dialect)_____

Adult(s) with whom child lives with: _____

LEGAL GUARDIAN(S)

Name: _____ Relationship: _____

Phone: (home) _____(work) _____ (cell) _____

E-Mail Address: _____

Name: _____ Relationship: _____

Phone: (home) _____ (work) _____ (cell) _____

E-Mail Address: _____

ALTERNATIVE PERSON(S) TO CALL IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Phone: _____ Language(s) Spoken: _____

Name: _____ Relationship: _____

Phone: _____ Language(s) Spoken: _____

PERSON(S) AUTHORIZED TO PICK-UP CHILD (Include Legal Guardians)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Is there a custody agreement _____ Yes_____ No. If yes please supply us with a copy of the agreement.

Emergency Health Information

Care Card Number: _____ Date of Last Tetanus Shot: _____

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Immunization Record on file with Richmond Health Department? Yes_____ No_____

Does your child have:

A medical condition/concern? YES NO

If yes, please provide further information:

_____

Allergies? YES NO (If yes, please complete Allergy Medical Form and attach)
If yes, please provide further information:

_____

Asthma? YES NO (If yes, please complete Asthma Medical Form and attach)
If yes, please provide further information:

_____

Has your child had a seizure in the past year? YES NO
If yes, please provide further information:

_____

Does your child require a special diet related to a medical condition? YES NO
If yes, please provide further information:

_____

Food sensitivities? YES NO
If yes, please provide further information:

_____

List all prescription and "over the counter" medications your child receives:

Medication	Times Given	Reason for Medication

Does your child require extra support from Supported Child Development, Speech Language Pathologist, Occupational Therapist or other agencies? YES NO

If yes, please provide further information:

_____

PLEASE READ CAREFULLY, CHECK BOXES AND SIGN BELOW

Child born in: ☐ 2016 ☐ 2017 ☐ 2018

Please indicate your Program preference below:

Program	Dates & Time	Cost
Week 1 (Science)	☐ August 3rd – 6th (9:00am – 12:30pm)	$80
Week 2 (Art)	☐ August 9th – 13th (9:00am – 12:30pm)	$100
Week 3 (Music & Movement)	☐ August 16th – 20th (9:00am – 12:30pm)	$100
Week 4 (Outdoor Adventure)	☐ August 23rd – 27th (9:00am – 12:30pm)	$100

Please initial each box below:

☐ I understand that fees are due upon registration

☐ I understand that I must give one week's written notice before the first day of the program to receive a full refund of program fees. 50% of the program fees will be refunded if withdrawal notice is given less than one week before the first day. No refunds will be given if withdrawal notice is given on or after the first day.

☐ I verify that my child will be 3 years of age and fully toilet-trained at the beginning of the program.

☐ I have read and understand all the information provided in the Tapestry Christian Early Learning Summer Program Parent Handbook that can be found on TCEL's website (www.tapestryearlylearning.com) under admissions

I agree and understand the registration policies and procedures.

Parent/Guardian Signature _____ **Date**_____

Please attach child's photo to this form

Tapestry Christian Early Learning

CHILD CARE EMERGENCY CONSENT FORM

CHILD'S NAME: _____ BIRTHDATE: _____
SURNAME, FIRST NAME(S) YEAR/MONTH/DAY

ADDRESS: _____

PARENT'S NAME: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

PARENT'S NAME: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ CELL PHONE: _____ PHONE: _____

OUT OF TOWN CONTACT: _____ PHONE: _____

CHILD'S DOCTOR: _____ PHONE: _____

DATE OF MOST RECENT TETANUS SHOT: _____

ALLERGIES / MEDICATIONS: _____

CHILD'S DENTIST: _____ PHONE: _____

CARE CARD NUMBER _____

_____ _____
DATE SIGNATURE OF PARENT / GUARDIAN

CONSENT

1) It is the policy of this facility to notify a parent when a child is ill or needs medical attention. Occasionally we cannot contact parents and we need to get immediate help for the child. Our procedure is to call for an ambulance.

2) Please sign the consent below so that we can take the appropriate action on behalf of your child. Return the signed consent to the facility immediately. We will take this consent with us to the emergency centre.

3) I hereby give consent for my child _____ to be taken to the nearest emergency centre when I cannot be contacted.

4) I hereby give consent for my child named above to receive medical treatment.

_____ _____
DATE SIGNATURE OF PARENT / GUARDIAN

REQUEST FOR ADMINISTRATION OF MEDICATION

Name of Facility:_____ Date:_____

Child's Name:_____ Birthdate:_____/_____/_____

Medication to be prescribed by a physician and/or non prescription medication provided by the parent – in the original container labelled with the child's name/dosage/time.

Parent or Guardian:_____ Phone #'s: _____

Physician's Name: _____ Phone: _____

Name of Medication: _____ Prescription Number:_____
(located on vial or bottle for prescription medications)

Medication is in the form of: Pills ☐ Drops ☐ Cream ☐ Other ☐ _____

Dosage: _____ Time: _____

Reason for Medication: _____
_____

Additional Comments: (possible reactions, consequences of missing medication, medication to be given with, etc.)

_____
_____
_____
_____

I hereby give permission for the staff to administer the above named medication to my child according to the orders and instructions I have provided. I agree to notify the staff and complete a new request form if there are any changes to the medication or instructions.

Signature of Parent/Guardian _____ Date:_____

RECORD OF MEDICATION ADMINISTERED

Date Commenced: _____ **Date Stopped:** _____

DATE	TIME	DOSAGE	COMMENTS	STAFF SIGNATURE

*Please use a separate form for each medication or refill.
*Please ensure unused medication is returned to the parent/guardian.

TAPESTRY
CHRISTIAN EARLY LEARNING

PHOTO & VIDEO RELEASE

I give permission for Tapestry Christian Early Learning to take pictures or videos of my child, _____, during school, special events or field trips. I understand that these photos or videos may be used in promotional materials such as brochures, flyers or on the preschool websites. Students or staff may also take photos for professional development assignments.

NO CHILD'S NAME WILL BE PUBLISHED

Please check your choice below.

☐ I give permission for my child to be photographed or video taped.

☐ I do not give permission for my child to be photographed or video taped.

_____ _____

Parent's Signature Date

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

IMMUNIZATION (VACCINATION) INFORMATION FOR CHILDCARE

Dear Parent/Guardian:

All childcare facilities in BC are required by law under the *Community Care and Assisted Living Act* to keep a record of each child's immunization history. These records are required to be made available to Vancouver Coastal Health Authority (VCH) medical health officers for public health programs. The information you provide on this form will be used to update your child's health record at VCH in order that: medical health officers may respond if a disease outbreak occurs in your childcare facility; public health staff can recommend immunizations which your child may be missing; and VCH is able to provide better care to your child as part of its public health programs. **Please complete and return this form to your childcare facility.**

PART A: CHILD AND FAMILY INFORMATION

PLEASE PRINT CLEARLY

Childcare facility _____

Child's name _____ (Surname) _____ (Given Name) _____ (Preferred Name)

Sex: M F Birthdate ____/____/____ (dd / mm / yyyy) _____ (Place of birth)

Child's personal health number (Care Card) _____

Home address _____ Postal code _____ Home phone _____

Father's Name _____ (Surname) _____ (Given Name) Daytime phone _____

Mother's Name _____ (Surname) _____ (Given Name) Daytime phone _____

Guardian's Name _____ (Surname) _____ (Given Name) Daytime phone _____

Doctor's name _____ Doctor's phone _____

PART B: CHILD'S VACCINATION INFORMATION

Attach a photocopy of your child's vaccination record OR complete the following record.

Has your child had chickenpox disease after one year of age? ☐ Yes ☐ No

Children who have not had the chickenpox vaccine or disease after 1 year of age need the vaccine.

VACCINES	DATES GIVEN							
	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
DIPHTHERIA								
TETANUS								
PERTUSSIS (WHOOPING COUGH)								
HEPATITIS B								
POLIO								
HAEMOPHILUS INFLUENZAE TYPE B (HIB)								
MENINGOCOCCAL CONJUGATE								
PNEUMOCOCCAL CONJUGATE								
MMR (MEASLES, MUMPS, RUBELLA)								
MEASLES (RUBEOLA)								
RUBELLA (GERMAN MEASLES)								
MUMPS								
HPV (HUMAN PAPILLOMAVIRUS)								
VARICELLA (CHICKENPOX)								
LIST OTHER VACCINES								

THIS IS AN IMPORTANT NOTICE.
PLEASE HAVE SOMEONE TRANSLATE IT.

AMHARIC *(Ethiopia)*	ይህ ጠቃሚ ማስታወቅያ ነው። እባክዎን ሌላ ሰው ያስተርጉምልዎት።
BURMESE	ဤစာသည်အရေးကြီးသောသတိပေးအကြောင်းကြားစာဖြစ်ပါသည်။ ကျေးဇူးပြု၍တစ်ယောက် ယောက်ကိုဘာသာပြန်ခိုင်းပါ။
CHINESE	這是一份重要通告，請找人爲您翻譯。
CROATIAN	OVO JE VAŽNO OBAVJEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
FRENCH	CECI EST UN AVIS IMPORTANT. PRIERE DE LE FAIRE TRADUIRE.
HINDI	यह एक बहुत ज़रुरी सूचना है। कृपया किसी से इसका अनुवाद करा लें।
ITALIAN	QUESTO È UN AVVISO IMPORTANTE, SIETE PREGATI DI FARVELO TRADURRE DA QUALCUNO.
KHMER *(Cambodia)*	នេះគឺជាសេចក្តីប្រកាសដ៏សំខាន់មួយ សូមអ្នករកអ្នកបកប្រែជូនអ្នក ។
KOREAN	중요한 안내사항입니다. 번역을 할 수 있는 분에게 도움을 청하시기 바랍니다.
PERSIAN *(Iran)*	این یک اطلاعیهٔ مهم است. لطفا از کسی بخواهید آن را برای شما ترجمه کند.
POLISH	TO JEST WAŻNE ZAWIADOMIENIE. POPROŚ KOGOŚ ABY JE PRZETŁUMACZYŁ.
PUNJABI	ਇਹ ਇਕ ਜ਼ਰੂਰੀ ਸੂਚਨਾ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਕੋਲੋਂ ਇਸ ਦਾ ਉਲੱਥਾ ਕਰਵਾ ਲਵੋ।
SERBIAN	OVO JE VAŽNO OBAVEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
SOMALI	KANI WAA OGEYSIIS MUHIIM AH. FADLAN QOF HA KUU TURJUMO.
SPANISH	ÉSTE ES UN AVISO IMPORTANTE. POR FAVOR, BUSQUE A ALGUIEN QUE SE LO TRADUZCA.
TAGALOG *(Philippines)*	ITO AY ISANG MAHALAGANG PAUNAWA. MANGYARING IPASALIN ITO PARA MAUNAWAAN.
VIETNAMESE	ĐÂY LÀ THÔNG BÁO QUAN TRỌNG. HÃY NHỜ NGƯỜI DỊCH GIÚP.

Personal information on this form is collected, used and disclosed by VCH in accordance with the Freedom of Information and Protection of Privacy Act. Statistical information may be provided to the Ministry of Health Services for healthcare planning, program evaluation and quality improvement purposes. If you have any questions about the collection and use of this information, contact your local public health nurse or VCH's Information Privacy Office at 604.875.5568 or email us at privacy@vch.ca

For vaccination schedules and more information
call your local public health nurse or go to www.immunizebc.ca

CARE PLAN

Child's Name: _____ Date of Birth: _____ Age _____ years _____ months

Program: _____ Attendance (days/times in program): _____

Parent or Guardian	Relationship	Contact Information

Other Professionals Involved (note if current or previous, and the capacity of involvement)

Professional/Organization	Contact Person	Contact Information	Capacity of Involvement

Rationale for Care Plan (Describe Child's Needs): _____

Recommendations from other professionals (attach any relevant documents or add comments below): _____

	Description	Person(s) Responsible	Date for Review
Staffing Requirements Reg. 19 (3), 34 (1)			
Adaptations/ Modifications to the Environment Reg. 13 (4), 58 (i)			
Adaptations/ Modifications to Program (activities/ routines) Reg. 58 (ii) 3(c) 44 (2)			
Dietary Requirements Reg. 58 (3)(a) 48(1)(2) 57(h)			
Medication Reg. 58 (3)(a), 57 (2)(e)(f)(h) 53 (1)(2)(3)(4)			
Health & Safety Requirements/ First Aid Reg 58(i) 23(1)			
Behavioural Guidance Reg. 58 (3)(d) 51 (2)			

Records on File Reg. 56(1)(2)(3_____

_____	_____	_____	_____
Parent/Guardian	Date	Parent/Guardian	Date
_____	_____	_____	_____
Supervisor/Child Care Staff	Date	Manager	Date

Asthma Emergency Action Plan for _____ year

Child's Name: _____ **Age:** _____

Centre Name: _____ **Centre Address:** _____

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian: _____

Phone (home/cell): _____ Phone (work): _____

Emergency Contact: _____

Phone (home): _____ Phone (work): _____

Health Care Provider: _____ Office Phone: _____

Picture ID

CHILD'S ASTHMA TRIGGERS ARE:

☐ change in temperature ☐ colds, infection ☐ dust, mites ☐ emotion (e.g. upset) ☐ mould ☐ physical activity ☐ pollen

☐ animals (list): _____

☐ foods (list): _____

☐ strong smells (list): _____

☐ Other: _____

CHILD'S ASTHMA SYMPTOMS ARE USUALLY:

☐ appears anxious
☐ coughing
☐ difficulty talking
☐ fast/shallow breathing
☐ pale
☐ hunched over
☐ short of breath
☐ wheezing
☐ in-drawing/tracheal tug
☐ other (list below):
☐
☐

CHILD'S EMERGENCY TREATMENT:

☐ Medication is stored: _____

☐ Medication expiry date: _____

☐ Field Trip Plans:

- **GIVE** _____
  (Name of medication)
- **Follow Instructions:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

- **If unsure, child is worse, or not getting better CALL 911**
- **CALL PARENTS**

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above information & plan:

_____ _____
Parent/Guardian Date

_____ _____

Life Threatening Allergy Emergency Action Plan

Child's Name: _____

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian: _____

Phone (home): _____ Phone (work): _____

Emergency Contact: _____

Phone (home): _____ Phone (work): _____

Primary Care Provider: _____ Office Phone: _____

Picture ID

CHILD'S ANAPHYLAXIS TRIGGERS ARE:

☐ Food (list): _____

☐ Insect stings (list): _____

☐ Other: _____

ANYONE HAVING AN ANAPHYLACTIC REACTION MIGHT HAVE ANY OF THESE SYMPTOMS "F.A.S.T.":

Face: Hives, itchy eyes, itchy nose, flushed/red face, swelling of face, lips or tongue

Airway: Difficulty breathing, swallowing or speaking, coughing or choking, change of voice, sneezing, nasal congestion

Stomach: Stomach pain, vomiting, diarrhea

Total Body: Hives, itching, swelling, weakness, dizziness, lightheadedness, loss of consciousness, anxiety, feeling of doom

CHILD'S EMERGENCY TREATMENT:

☐ Medication is stored where?

☐ Epinephrine auto-injector – expiry date:

☐ Field Trip Plans:

DO NOT WAIT FOR SYMPTOMS TO GET WORSE OR NEW SYMPTOMS TO BEGIN

- **GIVE EPINEPHRINE**
- **CALL 911**
  - Specify "allergic reaction" & that epinephrine has been given by auto-injector
  - Provide location & telephone number
  - Centre name: _____
  - Centre address: _____
  - Centre phone #: _____
- **Keep child lying down with feet elevated; if unconscious or vomiting, put in side-lying position.**
- **CALL PARENTS**
- **Always send child to hospital after receiving epinephrine**

Epinephrine is the first line medication which should be used for the emergency management of a person having a potentially life threatening allergic reaction.

Antihistamines (e.g. Benadryl ™) and asthma medications should not be used instead of epinephrine for treating anaphylaxis.

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above information & plan:

_____ _____

Parent/Guardian Date

_____ _____

Child Care Staff Date